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PRACTITIONER OR PROVIDER: ARE THEY MUTUALLY EXCLUSIVE?

Richard G. Sanderson, MD

My years in our specialty date from the mid-1960s to the present. The earlier years have been termed by some "the good old days" and the more recent years, "the time of managed care." My intention is to discuss some of the challenges presented by changes inherent in this "new medicine" and to examine whether the physician's roles of practitioner and provider are mutually exclusive.

In the early 1960s, health care started to be thought of as a right of every citizen, rather than a privilege for those who could afford it. Medicare and Medicaid systems were established for the elderly and the indigent. With rapid and continuing advances in medical technology, people lived longer and increasing numbers of elderly patients entered the system. Over a period of many years, cost shifting from commercial insurance payments (many of them paid by business corporations) was used to supplement the underfunded Medicare and Medicaid programs. With rapidly escalating expenses, cost controls were initiated. The diagnostic related groups (DRGs) led to improved efficiencies in the hospital segment, and the resource-based relative value scale (RBRVS) had a similar effect on the physician segment. However, American corporations, the government, and other entities still desired more cost control, and further health care reform was underway with the proliferation of managed care programs.

When the concepts of managed care were first introduced many years ago, many physicians reacted as though there had been a death in the family. Indeed there had been—the demise of the traditional fee-for-service programs. Their responses bring to mind the coping mechanisms portrayed in Elisabeth Kubler-Ross's book, *On Death and Dying,* which defined the five stages of reaction to death: denial and isolation, anger, bargaining, depression, and, finally, acceptance. I would venture to say that many of us have experienced some of these reactions as the managed care revolution has become increasingly prevalent.

Today, all of America's physicians are significantly affected by managed care to widely varying degrees in different parts of the country. Enrollment in health maintenance organizations (HMOs) varies from state to state, but interestingly, the Western region, especially California, Arizona, Oregon, and Colorado, have some of the highest penetrations of managed care in the country.

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Address for reprints: Richard G. Sanderson, MD, 5540 Circulo Terra, Tucson, AZ 85750.

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The "new medicine" affects almost every facet of our daily lives in medicine, particularly in the specialty of cardiothoracic surgery. Same-day admission for operations was the simplest form of cost control. Now a whole new array of techniques has been introduced to decrease costs. Standardization of equipment in the operating room (including suture packs, instruments, oxygenators, tubing packs, and cardioplegia systems) has led to more effective and competitive bidding by suppliers and, consequently, to a significant reduction in cost. Short-acting anesthetic agents have now become commonplace in the operating room, and stays in the intensive care unit are routinely 24 hours or less, in large measure because of early extubation. The fast-track algorithm for ventilator weaning in my hospital has become more cost-effective because it is now based on very few arterial blood gas determinations and more frequent pulse oxygen saturations and end-tidal carbon dioxide values. Standardization of postoperative and transfer orders has also led to further efficiencies. Rapidly advancing care maps have emphasized early ambulation, aggressive pulmonary treatments, and early initiation of rehabilitation efforts. Hospital length of stay has been dramatically shortened, so that a high proportion of patients who have had cardiac operations are now being discharged on the third to fifth postoperative day. Facilities for additional help with home care have allowed earlier discharge with little or no disadvantage to the patient.

However, sometimes patients do not fit within these cost-containing short-track protocols. Patients with preexisting prosthetic valves who need additional valve or coronary surgery may require intravenous heparin as the warfarin sodium (Coumadin) is stopped, somewhat difficult to administer outside the hospital setting. Patients with endocarditis usually require aggressive antibiotic management before valvular surgery. Similarly, patients are sometimes slow to recover in the postoperative period, often because of pulmonary complications, arrhythmias (especially atrial fibrillation), and lethargy (often accompanying low hemoglobin levels). In these clinical instances, the health care organizations are often hesitant to authorize additional hospital days, thereby initiating conflict between that organization and the people who provide the patient's care.

Responses to managed care programs have varied in different practices, but one of the major changes has been to increase the size of the practice groups. The days of a single practitioner, or even a small specialty group, are limited. Such groups are becoming much less common in today's environment. To compete for managed care contracts, independent physicians or small groups of physicians have banded together in ever-enlarging groups. Often, the new groups bring together physicians who have been staunch competitors of many years' duration. However, it is amazing how well these ex-competitors effectively and harmoniously now work together for the common good of the new corporation. In Tucson, for example, the practice group with which I am associated covers six hospitals, five with cardiac surgery programs. Four different HMOs have patients in two or more of those hospitals. By expanding our group to much larger numbers, we have been able to compete for contracts to provide services in these multiple hospitals.

However, increase in practice size is not without its distractions. With larger numbers and a much wider diversity of backgrounds and experiences, decision-making within the group becomes a longer and more difficult process. Furthermore, the agendas for corporation meetings are now heavily weighted toward discussing contracts and the effects of capitation agreements, answering requests for proposals (RFPs) to provide services to the HMOs, planning for marketing the larger group practice, and discussing methods of improving efficiencies and effectiveness of the physicians' activities. It seems sometimes that caring for the *practice* is now becoming as time-consuming as caring for our *patients.*

In this new and different setting in dealing with managed care, I think that it becomes even more important for the physician's attention to be focused and refocused on the details of patient care, new techniques and treatments, the results of operative procedures (particularly mortality and morbidity), and the perceived satisfaction of the patients, their families, and referring physicians with his or her efforts. Fortunately, many HMOs are becoming increasingly cognizant of quality of care and outcome issues, and these concepts are becoming more important in their selection of specialty provider panels.

Managed care has brought on many changes, some of which present dilemmas in our daily approach to patient care. For example, if a patient undergoes coronary angiography late in the week, the managed care organization expects the patient's operation to be done promptly. Saturdays and Sundays are perceived by them as regular working days.

However, the hospitals, with their decreased reimbursement from almost all income sources, do not provide full staffing in the operating rooms on the weekends, and cardiac procedures have to be declared emergencies to be accomplished. The physician is therefore faced with a dilemma of declaring a routine case an emergency or waiting until the start of the following week, thereby being labeled by the HMO as a poor utilizer. Some groups have purposely not scheduled routine elective operations for out-of-hospital patients on Fridays or Mondays, reserving these times for the managed care in-hospital patients.

In the converse situation, we are occasionally faced with the problem of needing to operate on a patient on the weekend and being unable to find someone from the HMO to authorize the procedure. If we proceed with the operation and subsequently the HMO refuses reimbursement, the hospital and the surgeon's corporation are affected negatively. If we do not proceed and something adverse happens to the patient, everyone is affected negatively.

Just as decreasing hospital reimbursement has caused a reduction in the numbers and quality of the caregivers in the hospital, capitation agreements with managed care organizations have also brought on similar reductions in the composition of the operating teams themselves. In times gone by, the operating room was fully staffed with experienced personnel, and the surgical team comprised multiple assistants, usually including a medical doctor. In the "new medicine," especially in capitated situations, the surgeon usually has but one assistant, who could be a qualified surgeon, but now much more frequently is a physicians' assistant, a certified surgical technician, or a registered nurse first assistant, all of the latter with variable amounts of experience and expertise. The dilemma in this scenario is not during the simple and routine operations, but during the difficult and high-risk procedures, in which the patient's best interests and the surgeon's needs would be best served by a fully trained medical doctor as an assistant should a crisis occur. To paraphrase an old saying, "When you're up the river without a paddle, it's nice to have someone along who really knows the canoe."

Managed care organizations seem to have even made communications more difficult. In trying to contact an HMO physician, you are often impeded by the telephone system, which answers with an impersonal recording: "If you need a prescription refill, dial 1; if you want to schedule an appointment, dial 2; if you need billing information, dial 3; if you think this is an emergency, dial 911." There is often no option for dialing a number for physician-to-physician communication, and you must choose an alternative number. You are then connected to the front desk, which transfers you to the internal medicine or cardiology department, which in turn transfers you to the intended physician's nurse, who makes sure that you, the calling physician, are on the line before she brings her physician to the telephone. If the physician's efforts in communication are this difficult, imagine the patient's frustrations in dealing with such a system in attempting medical problem-solving.

The so-called gag rule is a technique used by some managed care organizations to prevent its physicians, under the threat of sanctions, from criticizing the HMO. However, the rule is sometimes extended to preventing physicians from discussing with the patient options of care that may not be offered by that managed care system. Most physicians have felt the gag rule to be not only onerous, but also an invasion of their duty to fully disclose treatment options to the patient, effectively denying the patient fully informed consent. Fortunately, many states are now providing relief from these gag rules by legislating against them.

Legislative action is also building in some states to supervise the activities of HMOs. Insurance commissions of many states have little knowledge to handle the plethora of HMOs and little authority to deal with problematic situations. The board of medical examiners does not become involved unless there is a specific complaint against an individual physician. No single agency in Arizona, for example, has clear statutory authority to investigate complaints of HMO medical care. However, Arizona's Senate Bill 1220, The Consumer Protection Bill, would have given the department of insurance the authority to regulate the state's HMOs and to investigate consumer complaints. This bill would have required the HMO to reveal, on a new disclosure form, the details of the controls they put on patients and physicians in an effort to lower health care costs and to reveal any bonuses or penalties to persuade physicians to restrict the use of hospitals, specialists, and other high-priced care. Unfortunately, this excellent legislation was vetoed by Arizona's governor amid widespread criticism, but I remain confident that a new bill will be reintroduced in the near future. Similar bills are under consideration in California and other states.

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I had previously mentioned that surgical practices have joined together to become a more powerful negotiating force with the managed care organizations. Cardiology practices have joined together for the same reason, again often combining vigorous competitors in the same program. For example, in Tucson, two large groups of cardiologists recently combined which together comprise more than 80% of the interventional cardiologists in private practice in the city. These large combinations of cardiologists play a very important role in the power structure in different hospitals, as primary hospital admitters, as HMO providers, and as independent groups of physicians.

Some of the techniques used by these enlarged cardiology groups are causing some concern among their cardiac surgical counterparts. Some of these groups are now bidding to the larger HMOs for cardiac surgical services (in addition to their own cardiology services). They contend in their proposals that they will provide the personnel for the operations, supervise the mortality and morbidity results, and ensure quality in outcomes and patient satisfaction. Although the HMO might perceive the advantage of such an arrangement as having to deal with only a single entity for all cardiac services, there are, in my mind, basic difficulties in maintaining the separation of medical and surgical disciplines in patient care and decision-making, as well as difficulties in the cardiologists' understanding of the intricacies of surgical management.

A second technique of the combined cardiology forces is the planning, financing, and building of a heart hospital, dedicated almost entirely to the diagnosis and treatment of cardiovascular disease. With the help and guidance of a national hospital construction company, these cardiologists have embarked on such a project, which is now in the early stages of construction. This program will immediately have very serious effects on the existing full-service hospitals in which cardiac surgery is now performed. Only the future will tell whether adequate peer review and the normal checks and balances inherent in independent medical and surgical disciplines will provide the patients with better care or improved results in such a setting.

Another recent innovation is the "possible angioplasty." Recently, these cardiologists, with strong hospital approval, have begun to require operating room standby for angioplasty procedures, even before the diagnostic angiogram has been performed. This practice has been highly convenient for the cardiologists and efficient for those patients who are shown to have obstructions appropriate for interventional procedures. On the other hand, it has caused problems in scheduling the surgeons' participation and has exacerbated the already limited availability of operating room space for routine cardiac operations.

These items are only examples of the power exerted by large combined groups of primary hospital admitters in our system. I feel certain that similar examples exist in other cities.

I would like to turn for a moment from the daily specifics of managed care interplay to a more abstract level. If a physician is an active member of an HMO, he is an employee of that company, and cost-containment is a mandatory part of his day-to-day activities. Similarly, even for tertiary specialists like ourselves on a provider panel, there are implications that we are working for the HMO. The unspoken dilemma exists as to our allegiance to the company and its cost-cutting techniques, as opposed to our long-standing relationship to and responsibilities for the patient. Rationing health care conflicts with physician advocacy for the patient. This dilemma is particularly true in capitated agreements where, in essence, the less you do the better you are compensated. In a recent article titled "Ethical Dilemmas of Managed Care," Dr. Josef Fischer[1] questioned, "Is the implied physician-patient contract still existent when the contractor is an insurance company and the physician's contract is with the insurance company?" I personally believe the answer is a resounding *yes!* For all physicians, our entire training and ingrained attitudes gained over many years of caring for our patients allow for no other response. As American Medical Association trustee Dr. Ted Lewers indicated, "The doctor has one sacred contract—and that's the contract with the patient." (Personal communication, 1996.) Patient advocacy remains the most cherished tenet of the philosophy of the American College of Surgeons, as it is for each of us as individuals. Truisms of the good old days are just as important in current times.

Dr. William Mayo once concluded: "The best interest of the patient is the only interest to be considered." Interestingly, that quote was recently found in a Phoenix magazine advertising the Scottsdale Mayo Clinic.

That message from the distant past brings to mind a wonderful little volume that I read in medical school, written in 1930 by Dr. Francis Weld Peabody.[2] After recently rereading that thoughtful text,

Table I. *Financial data of Arizona's five largest HMOs**

HMO	*Members*	*Medical care*	*Profits*	*Profits/100,000 members*	*CEO cash compensation*
BC & BS	649,409	79.8%	$10.4 million	$1.63 million	$565,841
Cigna	384,995	76%	$37.7 million	$9.82 million	$328,108
Intergroup	307,423	79%	$26.3 million	$8.57 million	$736,988
FHP	171,399	84%	$38.6 million	$22.57 million	?
Partners	116,128	83%	$2.9 million	$2.5 million	$194,779
Average		80.4%		$7.2 million	$456,429
Medicare		97%			

CEO, Chief executive officer.
*Adapted from the *Arizona Daily Star,* Tucson, Arizona, May 26, 1996.

I have selected a few quotations that are pertinent even today.

> "There has been no change at all in the old relationship between the doctor and his patient and in the intimate and sympathetic friendship with which the counsel and service of the one are met by the gratitude and respect of the other."

> "It is the desire for this human relationship [between the physician and the patient] with its opportunity for sympathetic intimacy and altruistic service that remains today . . . the dominating impulse in drawing men to the study of medicine."

> "One of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is in caring for the patient."

> "Any reorganization of the medical profession that threatens the personal bond between doctor and patient is to be viewed with suspicion. . . ."

Dr. Peabody's observations on the doctor-patient relationship from almost two thirds of a century ago are in surprisingly close agreement with those of a contemporary author, Dr. Jeffrey Thurston,[3] who in 1996 published "Death of Compassion: The Endangered Doctor-Patient Relationship." A few quotes from his book are also appropriate to today's discussion*:

> ". . . managed care, coupled with a lack of tort reform, is unraveling our system by inexorably destroying what we once knew as the physician and replacing him with a provider."

> "Unless you take action to stop it *proactively,* you're going to give up . . . the freedom to choose. And even worse, you're going to create a system in which you may be lucky to find in a physician the virtues that once were requisite."

> "If we destroy the joy of medicine for the physician, take away his relationship to the patient and afford him the same position in the national psyche as any other worker, we will lose more than we ever thought possible."

*Published with permission of Dr. Jeffrey Thurston.

Although medicine and surgery in today's world are much more concerned with financial aspects—cost-containment, declining reimbursements, withholds for myriad reasons—there is still an implied moral contract between the physician and the patient. Illness compels the sick patient to place himself or herself in the hands of the physician, and that act itself is very meaningful in establishing a moral contract. Indeed, it is a covenant of trust, which is the very basis of our profession. The attitudes of commercialism in today's marketplace of medicine are tending to erode that trust, and it is becoming increasingly important that the basic human values be maintained. A recent statement in *JAMA* outlines this concept quite nicely: "By its traditions and very nature, medicine is a special kind of human activity—one that cannot be pursued effectively without the virtues of humility, honesty, intellectual integrity, compassion, and the effacement of self-interest."[4]

Even in today's rapidly changing medical environment, I believe that reliance on these virtues will hold our profession on a steady course. These virtues served very well the "practitioner" of previous times and can and should be the foundation of the "provider" in managed care medicine.

At present, most physicians and surgeons feel forced to adopt confrontational attitudes when dealing with managed care programs, because for many years we have been forced, mostly by threats of exclusion, to accept what their administrators have demanded—more regulations, more paperwork, eroding respect for the doctor-patient relationship,

and continually decreasing reimbursement. As an example, one of our largest HMOs, with which we had been successfully capitated on a per-member per-month price basis, abruptly converted to a percentage-of-premium basis. Then when the HMO lowered its premium rate competitively, the reimbursement to physicians was automatically decreased. This change in physician payment was accomplished with very little discussion with the providers, and meaningful negotiations were supplanted by administrative fiat: Take it or leave it!

Much of today's focus in managed care is cost-containment, with between 15% and 30% of the health care dollar going to plan administration costs, to compensate management intermediaries, and to profits, and the remainder going to patient care. One has only to look at some of the salaries and benefits of the plans' administrators to realize that the patients (as well as the physicians and hospitals) are not reaping the full benefit of their health care premium dollars.

From the *Arizona Daily Star,* I have abstracted data on the five largest Arizona HMOs. About 80% of the health care dollar is spent on medical care; the HMOs' profits average about 7 million dollars per 100,000 members; and the average cash compensation of the chief executive officers is almost a half-million dollars (Table I).

Patients may in time become disenchanted with what they perceive as hurried, superficial, and impersonal care, with restrictions of treatment options, and with limitations of choices of physicians and hospitals. The old admonition that "a satisfied patient is the hallmark of success in the practice of medicine" still has significant merit.

Predictions as to the future course of health care on a national level are merely conjectural and are as numerous as the number of predictors. Medical savings accounts, Medicare HMOs, and other Medicare reforms are but a few of the national scenarios currently being debated. One thing seems likely: managed care, in some form, is here to stay.

My own view is that the pendulum is going to swing from emphasis on cost-containment only to more emphasis on quality of care. This shift in approach may be dictated in part by legislative action, as the state and federal governments assume a more active role in supervising and controlling managed care. Further impetus may come from organizations that monitor quality on a national level, such as the Foundation for Accountability, the National Committee for Quality Assurance (NCQA), and the Health-Plan Employer Data and Information Set (HEDIS). Patients' perceptions will also help the pendulum to swing away from cost considerations only.

On a local or regional level, I perceive the optimal health care system will have a single group of committed physicians, working in one supportive hospital system, paid for and managed by a single payor. Ideally, each part of this vertically oriented system will have the motive, initiative, and desire to make the system as efficient and cost-conscious as possible, while still providing optimum patient care. When each segment shares equally in the risks and the benefits of the outcome of the overall system, mutual respect and cooperation, rather than confrontation, become the key elements. In such a system, the attitudes of the providers of today will more easily become those of traditional practitioners of the past. The secret of the care of the patient will indeed be once again in caring for the patient. The doctor-patient relationship can then return to its appropriate position of primary importance, allowing the terms "practitioner" and "provider" to become synonymous.

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